LITTLETON REGIONAL HEALTHCARE

ADULT VOLUNTEER APPLICATION

Name: _____ Date: _____

Mailing address: _____

Home phone: _____ Cell phone: _____

Email address: _____Date of birth: _____

Prior volunteer experience: _____

_____

Reference name and number: _____

_____

Health concerns or special needs that may impact your volunteerism: _____

_____

Do you speak any language other than English? Yes_____ No_____

If yes, what language(s): _____

Name of person to call in event of an emergency: _____

Their phone number: _____ Relationship to you: _____

Day(s) of the week you are available to volunteer: _____

Areas/departments that interest you: _____

Times you are available: _____

Do you have special talents and/or computer skills? Yes_____ No_____

If yes, please explain: _____

Please complete this form and return to:

Amy B. LaSalle, Director
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Littleton Regional Healthcare
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alasalle@lrhcares.org